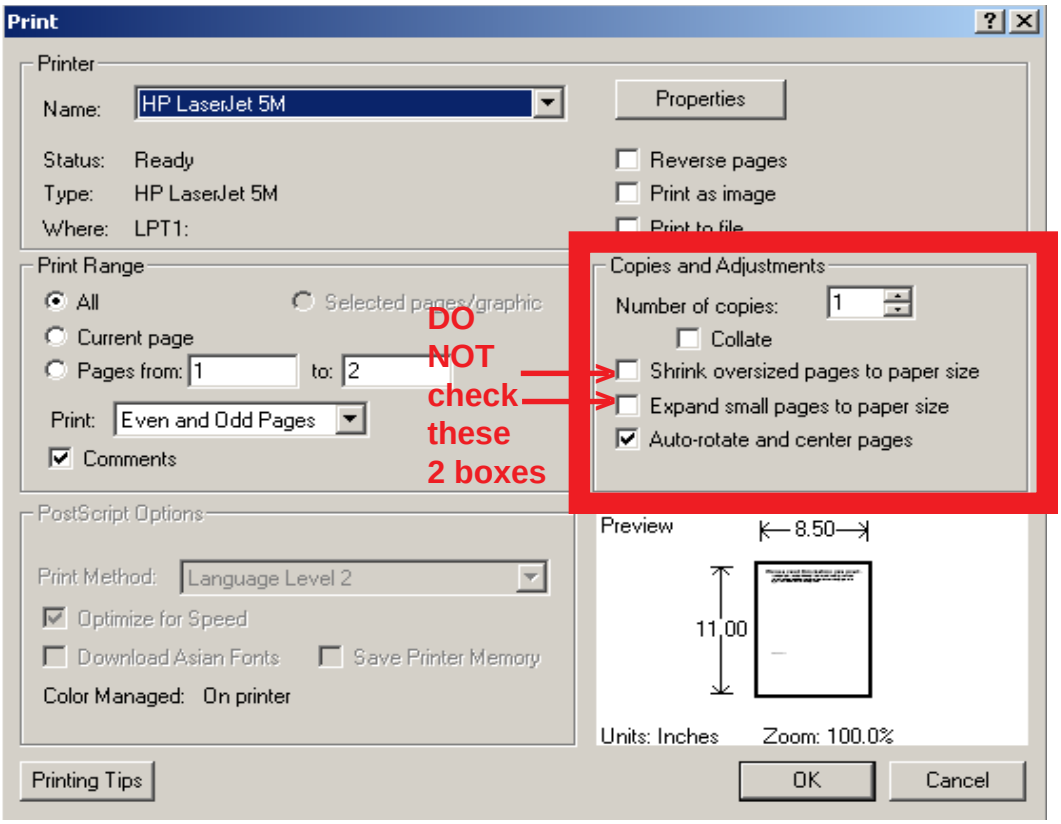
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Mental Health Counselor License Application Packet

1. 670-036 .... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 670-018 .... Application Instructions for Mental Health Counselor License .....2 pages
3. 670-017 .... Application for Mental Health Counselor .....4 pages
4. 670-027 .... Verification of Mental Health Supervised Postgraduate Experience ..... 1 page
5. 670-020 .... Out of State Verification of Registration / Certification / Licensure as a Mental Health Counselor ..... 1 page
6. 670-050 .... Accommodation Request ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Mental Health Counselor

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 670-036 (REV 9/2003)

1F 0207030000 00449

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Washington State Department of Health

Application Instructions For Mental Health Counselor License

Application Fee **$25.00** Initial Licensure Fee **$25.00** **ALL FEES ARE NON-REFUNDABLE** Send the application and fee to: Department of Health Counselor Programs PO Box 1099 Olympia, WA 98504-1099	If you are sending **supporting documents** separate from the four-page application form, please mail to the following address: Department of Health Counselor Programs PO Box 47869 Olympia, WA 98504-7869 (360) 236-4916 (360) 236-4918 fax

1. Demographic Information

Please complete the application form. To assure appropriate review, all information should be typed or print clearly. A resume will ***not*** substitute for completion of the application. It is the applicant's responsibility to keep the Department of Health, Counselor Programs, informed of any address change.

2. Previous Certification/Licensure/Registration

List all states in which you now hold or have held a certification, license, or registration to practice as a Mental Health counselor or any other professional certification, license, or registration. Also, include those states in which you may have applied and a certification, license, or registration was not granted. Please include an explanation. This form may be duplicated. Please send the out-of-state Verification form to each state in which you held a Mental Health certification, license, or registration, even if it has now expired.

3. Examination Data

If you have taken the **NCE** or **NCMHCE** examinations, you are considered to have met the examination requirement. The state in which you took the examination should verify the score. If the state in which you took the examination does not verify the score, you will then need to obtain written verification from **NBCC**, sent *directly* to the department.

Note: regarding the "Method of Licensure", EXAM = examination, END = endorsement, and GP = grandparenting.

4. Personal Data Questions

If any questions on the Personal Data page have a "Yes" response, the supporting documents and explanation required for that answer must be attached.

5. Education

Graduation from a master's or doctoral level educational program in mental health counseling or a related field, from an approved college or university. Please request official transcripts to be sent directly from your college or university to the Department of Health.

6. Graduate Level Coursework

List course number and course title with the corresponding content area. One course may satisfy more than one content area.

7. Aids Education And Training Attestation

Please read carefully the AIDS education and training attestation. After you have completed a minimum of four (4) hours of AIDS education, sign and date the attestation.

8. Applicant's Attestation

After you have familiarized yourself with the statutes cited in your counselor law book, sign and date the attestation.

Experience Requirement

Minimum of thirty-six months of full-time counseling or three thousand hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor in an approved setting.

Verification of Mental Health Supervised Postgraduate Experience Forms must be sent to approved supervisors that can verify a minimum of 36 months of full-time counseling or 3000 hours of postgraduate supervised work experience, 1200 of the 3000 hours must be direct counseling with individuals, couples, families, or groups and 100 hours must be spent in immediate supervision with a qualified licensed mental health counselor. If you had more than one supervisor, a separate form must be used for each supervisor.

Out-Of-State Verification Form

This form is required if you hold or have held a certification, license, or registration to practice as a Mental Health Counselor or any other professional certification, license, or registration.

Examination Information

- Once you have been approved to take the examination, you will be sent an approval letter. This letter gives you further information on how to register for the examination. You will be taking the examination directly from the National Board of Certified Counselors (**NBCC**).
- Your completed examination registration form and $120 examination fee must be sent directly to: **NBCC, PO Box 651051, Charlotte, NC 28265-1051**.
- The Department receives score reports within 8 weeks of administration from the testing company. You will be notified by mail of the examination score. Scores **will not** be given over the phone. Once you have completed all the requirements and have passed the **NCE** or the **NCMHCE** examinations and the $25 initial certification fee has been received, licensure will be granted.

  OR

- If an examination is not required and all other requirements have been met, including the $25 initial licensure fee, licensure will be granted.

Examination dates and cutoff dates for 2003 examinations:

Exam Date	Application and Application Fee	Supporting Documents
October 18, 2003	July 18, 2003	August 18, 2003
January 17, 2004	October 17, 2003	November 17, 2003
April 24, 2004	January 24, 2004	February 24, 2004
July 24, 2004	April 23, 2004	May 24, 2004
October 23, 2004	July 23, 2004	August 23, 2004

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE NO:	LICENSE DATE:
APPROVED BY:	
VALIDATION INFORMATION:	

LICENSE #

Application for Mental Health Counselor

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

GENDER ☐ Female ☐ Male | BIRTHDATE | PLACE OF BIRTH

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, other name(s):

2. Previous Certification/Licensure/Registration

List **all** states (including Washington) where certifications/licenses/registrations are or were held. Specifically list certifications/licenses/registrations granted by examination, endorsement, or grandparenting.

STATE	CERTIFICATION/LICENSE TYPE	License/Registration/Certification		METHOD OF LICENSURE		
		YEAR ISSUED	NUMBER	EXAM	END	GP

An "Out of State Verification for Registration/Certification/Licensure" form is enclosed and must be sent to each state listed above. Enter your full name and birthdate at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

3. Examination Data

Have you taken and passed the National Board of Certified Counselors?

NCE ☐ Yes ☐ No Year? _____

NCMHCE ☐ Yes ☐ No Year? _____

4. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

5. Education

Please provide a chronological listing of graduate school(s) attended, major, and month and year the degree was granted. *A transcript is to be requested from the graduate school(s) and sent **directly** from the graduate school to the Department of Health, Mental Health Counselor Section per instructions.*

GRADUATE SCHOOL	DEGREE AND MAJOR	DEGREE GRANTED	
		MONTH	YEAR

6. Course Content Identification For Licensed Mental Health Counselors

Requirement: A masters or doctoral degree in mental health counseling or a related field with the substantial equivalent in subject content.

Subject content includes a core of study relating to counseling theories, counseling philosophy, counseling practicum, counseling internship, and should incorporate content in professional ethics and law and shall include at least five content areas (a) through (h) of this subsection and at least two additional content areas from the entire list. One course may satisfy more than one content area.

CONTENT AREA	COURSE #	COURSE TITLE
a) Assessment / diagnosis		
b) Ethics / Law		
c) Counseling individuals		
d) Counseling groups		
e) Counseling couples and families		
f) Developmental psychology (may be child, adolescent, adult or life span)		
g) Abnormal psychology/psychopathology		
h) Research and evaluation		
i) Career development counseling		
j) Multicultural concerns		
k) Substance / chemical abuse		
l) Physiological psychology		
m) Organizational psychology		
n) Mental health consultation		
o) Developmentally disabled persons		
p) Abusive relationships		
q) chronically mentally ill		

7. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant_____ Date _____

Official Use Only

Washington State Records Center

Washington State Department of Health

Verification of Mental Health Supervised Postgraduate Experience

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill out Section 1 and forward the verification form to the supervisor for completion.

1. Print or Type Clearly:

NAME LAST	FIRST	MIDDLE	BIRTH DATE
ADDRESS			
CITY ZIP	STATE		

2. Supervisor:

The above individual seeks licensure as a mental health counselor in Washington and requires verification of postgraduate supervision and postgraduate professional experience.

SUPERVISOR NAME	CURRENT PHONE
CURRENT STREET ADDRESS	
CITY / STATE / ZIP	

3. Postgraduate Supervised Experience:

Applicants must have a minimum of **thirty-six months** of full time counseling or **3,000** hours of postgraduate mental health counseling under the supervision of a qualified mental health counselor. Please complete the actual months under your supervision.

Months of Supervision

From: / / / (MO DAY YR)	To: / / (MO DAY YR)

Supervised Work Experience—Postgraduate professional experience consists of a minimum of **3,000** hours; at least **1,200** of the total hours must be direct client contact and **100** hours must be individual formal meetings. Please complete the actual number of hours under your supervision.

Experience Requirement	Number of Hours
Total number of hours of supervised work experience	
Total number of hours of direct client contact	
Total number of hours of individual formal meetings	
Total of Professional Experience Hours	

Supervisor

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest that I meet or exceed educational and supervision requirements for certification.

Signature: _____ Date: _____

Return this form to:

Counselor Programs
PO Box 47869
Olympia Washington 98504-7869

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Washington State Department of Health

Out of State Verification of Registration / Certification / Licensure as a Mental Health Counselor

Applicant Name: _____ Birthdate: _____

I, _____ , Secretary of _____ ,
OFFICIAL NAME OF BOARD

hereby certify that _____

was granted state:
Registration/Certificate/License
Number: _____ to practice _____

in the State of _____ on the _____ day of _____ , 20 _____.

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

On the basis of: _____

Did applicant take and pass the NBCC Exam? ☐ Yes ☐ No Passing Score: _____

☐ Yes ☐ No 100 hours Postgraduate Supervision

☐ Yes ☐ No 3000 hours Postgraduate Professional Experience
1200 hours must be on an individual basis

☐ Yes ☐ No 36 months full time counseling

Status of License: ☐ Current Expiration Date: _____

☐ Expired Date _____

S E A L

_____
OFFICIAL NAME OF BOARD PHONE

_____
SECRETARY

_____
DATE CERTIFICATION PREPARED

Return to: **Department of Health**
Counselor Programs
PO Box 47869
Olympia, WA 98504-7869

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Washington State Department of Health

Accommodation Request

If you have a disability and may require some accommodation in taking the examination, please complete and submit this form by the application deadline. The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. [Section 504 of the Rehabilitation Act (29 USC 12101)].

Name: _____

Address: _____

_____

Phone: _____ Social Security Number: _____

Accommodations requested for the: _____ Licensure Examination.
DATE

Type of Disability: _____

Requesting the following accommodation(s) at the testing site: _____

Signed: _____ Date: _____

Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (learning specialist, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____.
TEST APPLICANT DATE

The applicant has the disability: _____,

Diagnosed by the following tests or studies: _____

I recommend the following accommodation(s) be provided for this individual: _____

_____

Name: _____

Address: _____

_____

Title: _____ Phone: _____

Date: _____ License Number: _____